DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435095	B. WING			03/25/2021		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND				STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059				
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
F 000	42 CFR Part 483, Sul Long Term Care facili	h survey for compliance with bpart B, requirements for lties, was conducted from /21. Good Samaritan Society	F	000	DEFICIENCY			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Julie Ramey Administrator

04/07/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete APR 0 7 2021 Even ID: W4CY11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR MEDIOARE & MEDIOARE GERTIOLS			THE REPORT OF CONTRACTOR				(X3) DATE SURVEY				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED					
		435095	B. WING			03/25/2021					
	ROVIDER OR SUPPLIER	OTI AND		130 6TH ST							
GOOD SA	WARIAN SOCIETY SCC	JILAND		SCOTLAN	COTLAND, SD 57059						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	C	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE				
E 000	Initial Comments Surveyor: 32332	5 - 1'	E	000							
	CFR Part 482, Subpa	ey for compliance with 42 art B, Subsection 483.73, dness, requirements for Long was conducted from 3/23/21 and Samaritan Society in compliance.									
	A DISTORTION OF STREET	DISTUDDI IED DEDDESENTATIVE'S SIGNATI IDE			TITLE		(X6) DATE				
LABORATORY	DIKECTOR'S OK PROVIDER	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE									

Julie Ramey Administrator

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these idoduments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. program participation.

Event ID: W4CY11

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Facility ID: 0078

If continuation sheet Page 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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435095 B, WNG 03/25/2	2021
OTDERY LODDES OF STATE TO CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE
Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/25/21. Good Samaritan Society Socialand was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	DATE

Julie Ramey Administrator

04/07/2

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a pian of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete PR 0 7 202

Event ID: W4CY21

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Facility ID: 0078

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South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WNG 03/25/2021 10675 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH ST GOOD SAMARITAN SOCIETY SCOTLAND SCOTLAND, SD 57059 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/23/21 through 3/25/21. Good Samaritan Society Scotland was found in compliance. S 000 S 000 Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/23/21 through 3/25/21. Good Samaritan Society Scotland was found in compliance.

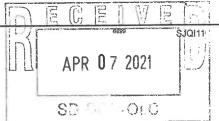
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Julie Ramey Administrator

STATE FORM



04/07/21

If continuation sheet 1 of 1